Calendar No. 359

109TH CONGRESS, 2d Session | SENATE | REPORT 109–215

TRAUMA CARE SYSTEMS PLANNING AND DEVELOPMENT ACT OF 2005

FEBRUARY 2, 2006.—Ordered to be printed

Mr. ENZI, from the Committee on Health, Education, Labor, and Pensions, submitted the following

R E P O R T

[To accompany S. 265]

The Committee on Health, Education, Labor, and Pensions, to which was referred the bill (S. 265) to amend the Public Health Service Act to add requirements regarding trauma care, and for other purposes, having considered the same, reports favorably thereon without amendment and recommends that the bill do pass.

CONTENTS

I. PURPOSE AND NEED FOR LEGISLATION

The purpose of the "Trauma Care Systems Planning and Development Act of 2005" is to assist State governments in the development, implementation, and improvement of statewide and regional systems of trauma care. By providing incentives to States to establish well-coordinated systems, severely injured individuals can receive specialized, high quality care as rapidly as possible following their injury. Experience has proven that death and disability for severely injured patients are both reduced dramatically when definitive care is provided within the so-called "golden hour" following their injury. Yet, according to the Centers for Disease Control

(CDC), only one fourth of the United States' population lives in an area served by a trauma system.

Trauma is the leading cause of death for Americans between the ages of 1 and 44 years and is among the top five causes of death in the general population of the United States. According to the CDC every year, more than 150,000 Americans die from traumatic injuries, many of which result from motor vehicle collisions, violence, and falls. Given the nation's renewed focus on enhancing disaster preparedness, it is critical that the Federal Government increase its commitment to strengthening title XII programs governing trauma care system planning and development.

Survival among severely injured patients requires specialist care delivered promptly and in a coordinated manner. Care begins at the scene of injury, continues through emergency transport to the trauma center, intensive care unit, hospital floor, and ultimately to rehabilitation. Optimal acute care depends on technical expertise and coordination between teams of providers, including first responders, trauma center teams, acute care and rehabilitative care teams.

A trauma care system is an organized approach to facilitating and coordinating a multidisciplinary system response to severely injured patients. It is inclusive of injury prevention, emergency department care, surgical interventions, intensive and general surgical in-hospital care, rehabilitative services, along with social services and support groups that enable the patient to return to society at the most productive level possible.

Trauma care and emergency medical services systems are an integral component of our Nation's health and public health infrastructure and an important public safety resource in all States. Throughout the United States, trauma systems face ongoing and increasing challenges of both natural and man-made disasters. The National Center for Injury Prevention and Control reports studies showing that as many as 35 percent of trauma patient deaths could have been prevented if optimal acute care had been available.

Strong Federal support for Title XII of the Public Health Service Act and the goals of the "Trauma Care Systems Planning and Development Act" will help States and communities in need of improved infrastructure to provide effective and efficient care to severely injured patients. A 1999 study in the Journal of Trauma, Injury, Infection and Critical Care reported that seriously injured patients have a 15 to 20 percent improved survival rate if the patients access a trauma system.

II. SUMMARY

This legislation reauthorizes Title XII of the Public Health Service Act for a period of 5 years; doubles the funding available for trauma system development under Parts A–C of Title XII for fiscal year 2006, from $6 million to $12 million; and authorizes $750,000 for fiscal year 2008 for an Institute of Medicine (IOM) study of trauma care systems.

First, the "Trauma Care Systems Planning and Development Act of 2005" improves the collection and analysis of trauma patient data with the goal of improving the overall system of care for these patients. Second, the bill adjusts States matching requirements for Federal grant funding; third, the legislation provides a self-evalua-

tion mechanism to assist States in assessing and improving their trauma care systems; and finally, it authorizes an IOM study on the state of trauma care and trauma research.

III. History of Legislation and Committee Action

The "Trauma Care Systems Planning and Development Act of 1990," (P.L. 101–590) which created Title XII of the Public Health Service Act (PHS), was enacted to improve trauma care systems nationwide. From 1992 to 1994, the Health Resources and Services Administration (HRSA) administered the Federal funds to execute the responsibilities specified in the act. The program's authority expired in 1995 and funding was discontinued. Title XII was reauthorized in 1998 for fiscal year 2000 through fiscal year 2002 in P.L. 105–392, the "Health Professions Partnership Act of 1998" and funding re-initiated in fiscal year 2001.

During the first session of the 108th Congress, S. 239, the Trauma Care Systems Planning and Development Act of 2003, was introduced on January 29, 2003, to reauthorize the program. The Committee on Health, Education, Labor, and Pensions reported the bill favorably without amendment on February 12, 2003. The Senate passed the bill on July 1, 2003 by unanimous consent. The House received S. 239 from the Senate and referred it to the House Energy and Commerce Committee, Subcommittee on Health. No further action was taken during the 108th Congress.

During the first session of the 109th Congress, S. 265, the Trauma Care Systems Planning and Development Act of 2005, was introduced February 2, 2005, to reauthorize the program. After accepting a substitute amendment offered by Senator Frist, the Committee on Health, Education, Labor, and Pensions reported the bill favorably by unanimous voice vote on February 9, 2005.

IV. Explanation of Bill and Committee Views

The bill has a variety of provisions, the explanation of and committee views on which follow below:

The bill reauthorizes and makes improvements to the Trauma Care Program under Title XII of the Public Health Service Act. This committee expects the program to continue to be administered by the Health Resources and Services Administration (HRSA). A Clearinghouse on Trauma Care and Emergency Medical Services was authorized in previous legislation but never established at the Department. As a result, the committee has collapsed clearinghouse functions into the general trauma care program.

The bill reduces the States' contribution to the Federal matching requirement for grants under the Trauma Care Program. It is hoped that this reduction will enable some States to be able to participate in the program and encourage other States to further develop their trauma care systems. The committee believes that although the Federal Government should provide assistance in ensuring the availability of quality trauma care for Americans, each State should be responsible for developing and maintaining a trauma care system that is tailored to its own needs. The revised matching requirement sustains the policy that State investments in trauma care exceed the Federal contribution.

The committee supports the Interagency Program for Trauma Research and strongly urges the NIH to continue with this important work to conduct basic and clinical research on trauma.

The Senate bill as reported out of committee reauthorized the program through fiscal year 2009. However, the committee notes that this program would be more appropriately placed in Title IV of the Public Health Service Act which authorizes the National Institutes of Health (NIH) and also is under the committee's jurisdiction. The committee fully intends to actively pursue reauthorization of the NIH and plans to retain authority for the Interagency Program for Trauma Research as part of that effort.

The bill adds a provision to an existing program for improving trauma care in rural areas that would increase coordination of State trauma systems with Emergency Medical Systems (EMS) operations in rural areas of the State. In rural areas, the barriers to coordination between first responders and State trauma systems may be greater. The committee expects that this change to the existing program will help to overcome some of those barriers.

The bill requests an Institute of Medicine report on the status of the Nation's trauma care and trauma care systems. The committee expects that this report will be important in properly evaluating trauma care systems and identifying priorities for trauma research in the future.

V. Cost Estimate and Unfunded Mandate Statement

U.S. Congress,
Congressional Budget Office,
Washington, DC, May 27, 2005.

Hon. Mike Enzi,
Chairman, Committee on Health, Education, Labor, and Pensions, U.S. Senate, Washington, DC.

Dear Mr. Chairman: The Congressional Budget Office has prepared the enclosed cost estimate for S. 265, the Trauma Care Systems Planning and Development Act of 2005.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Tim Gronniger.

Sincerely,

Douglas Holtz-Eakin,
Director.

Enclosure.

S. 265—Trauma Care Systems Planning and Development Act of 2005

Summary: S. 265 would amend the Public Health Service Act to authorize several emergency services and trauma care programs administered by the Health Resources and Services Administration (HRSA). Those programs include grants to States for the development of trauma care systems and an emergency care residency training program. S. 265 also would require HRSA to contract for a study on trauma care and trauma research.

Assuming that the necessary amounts (including annual adjustments for anticipated inflation) are appropriated for fiscal years 2006 through 2009, CBO estimates that implementing S. 265

would cost $47 million over the 2006–2010 period. The legislation would not affect direct spending or receipts.

The bill contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA). The bill would authorize and increase appropriations for grant programs designed to improve the quality of trauma care systems. States that choose to apply for those grants would have to provide matching funds, but any costs they face would be incurred voluntarily.

Estimated cost to the Federal Government: The estimated budgetary impact of S. 265 is shown in the following table. The costs of this legislation fall within budget function 550 (health).

	By fiscal year, in millions of dollars—					
	2005	2006	2007	2008	2009	2010
SPENDING SUBJECT TO APPROPRIATION						
Spending Under Current Law:						
Estimated Budget Authority [1]	3	0	0	0	0	0
Estimated Outlays	3	2	1	0	0	0
Proposed Changes [2 3]						
Estimated Authorization Level	0	13	13	13	13	0
Estimated Outlays	0	4	9	13	13	9
Spending Under S. 265:						
Estimated Authorization Level [1]	3	13	13	13	13	0
EstImated Outlays	3	6	10	13	13	9

[1] The 2005 level is the amount appropriated for that year.
[2] The bill also would authorize funding for 2005, but this estimate assumes that no additional funds will be appropriated this year.
[3] Including adjustments for anticipated inflation, the estimated outlay changes would total $47 million over the 2006–2010 period. Without such adjustments, the five-year total would be $46 million.

Basis of estimate: S. 265 would authorize two trauma-related programs and would require HRSA to contract for a study on the current state of trauma care. Assuming the appropriation of the necessary amounts, CBO estimates that implementing S. 265 would cost $47 million over the 2006–2010 period.

HRSA currently administers grants to states for the planning, development, and improvement of trauma centers and systems. S. 265 would authorize the appropriation of $12 million in 2005 and such sums as necessary through 2009 for those activities. In 2005, $3 million was appropriated for those activities, although the authorization expired in 2004. For this estimate, CBO assumes that no additional funds will be appropriated for the current year.

The planning grant part of that program provides federal matching payments to funds spent by states. Under prior law, the federal government did not require contribution of state funds in the first year, but required a matching payment of $1 for every $1 of state spending in the second year, and a $3 match for every $1 spent in subsequent years. In 2005, however, because the appropriation is not sufficient to fund that schedule of matching payments, HRSA is providing roughly equal amounts to each participating state.

Under the bill, states would receive grants without the contribution of their own funds for the first two years. In the third year, the federal government would provide a matching payment of $1 for every $1 of state spending. In the fourth and fifth years, the federal government would provide a matching payment of $1 for every $2 of state spending.

State participation under the current, less-generous program is very high. The authorization level for 2005 under S. 265 for this program would be four times higher than the 2005 appropriation level of $3 million. Based on information provided by HRSA about states' trauma-planning activities and on historical spending patterns for this program, CBO estimates that the cost of implementing this provision would be $4 million in 2006 and $46 million over the 2006–2010 period.

S. 265 also would authorize a residency training program in emergency medicine. The bill would authorize $400,000 each year through 2009 for grants to public and private nonprofit entities for the development of residency programs with an emphasis on treatment and referral of domestic violence cases. CBO estimates that implementing this provision would cost $1.6 million over the 2006–2009 period.

S. 265 would require the Secretary of Health and Human Services to contract with the Institutes of Medicine or a similar entity to conduct a study on trauma care. The bill would authorize the appropriation of $750,000 in both 2005 and 2006. Assuming the availability of appropriated funds, conducting the study could cost up to $1.5 million.

Intergovernmental and private-sector impact: The bill contains no intergovemmental or private-sector mandates as defined in UMRA and would impose no costs on state, local, or tribal governments. The bill would authorize and increase authorized funding for a grant program designed to improve the quality of trauma care systems. States that choose to apply for those grants would have to provide matching funds, but any costs they incur would be voluntary.

Estimate prepared by: Federal costs: Tim Gronniger; impact on state, local, and tribal governments: Leo Lex; impact on the private sector: Peter Richmond.

Estimate approved by: Peter H. Fontaine, Deputy Assistant Director for Budget Analysis.

VI. Application of Law to the Legislative Branch

The committee has determined that there is no impact of this law on the Legislative Branch.

VII. Regulatory Impact Statement

In accordance with paragraph 11(b) of rule XXVI of the Standing Rules of the Senate, the committee has determined that there will be minimal increases in the regulatory burden imposed by this bill.

VIII. Section-by-Section Analysis

Section 1. Short title

"Trauma Care Systems Planning and Development Act of 2005".

Section 2. Amendments

This section reauthorizes the current grant program to enable a State to develop, implement, and maintain statewide trauma care systems. This section collapses the duties of the Clearinghouse into the general program description and authorizes the Secretary, act-

ing through HRSA, to promote the reporting and collection of trauma data in a consistent and standardized manner. This Section also eliminates authorization for the Clearinghouse on Trauma Care and Emergency Medical Services (EMS).

This section promotes standardized trauma data collection requirements under the trauma care component of the State plan for EMS and promotes coordination with State disaster emergency planning and bioterrorism hospital preparedness planning under the trauma care component of the State plan for EMS. It also requests the Secretary to update the model trauma care plan.

This section authorizes the Secretary to make grants for programs for improving trauma care in rural areas. Grants are authorized to increase coordination of emergency medical services (EMS) in rural areas with statewide trauma systems, under existing rural grant programs.

The section requires matching funds for fiscal years subsequent to the first fiscal year of payments. The section amends the requirement of State matching funds in the following manner: first fiscal year—no match; second fiscal year—$1 State: $1 Federal; third fiscal year—$1 State: $1 Federal; fourth fiscal year—$2 State: $1 Federal; fifth fiscal year—$2 State: $1 Federal; and subsequent fiscal years—$2 State: $1 Federal.

This section authorizes the appropriation of $12,000,000 for fiscal year 2006 and such sums as may be necessary for fiscal years 2007 through 2010.

This section requests an Institute of Medicine study on the state of trauma care and trauma research and authorizes $750,000 for fiscal year 2008 for such study.

IX. CHANGES IN EXISTING LAW

In compliance with rule XXVI paragraph 12 of the Standing Rules of the Senate, the following provides a print of the statute or the part or section thereof to be amended or replaced (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

PUBLIC HEALTH SERVICE ACT

* * * * * * *

TRAUMA CARE SYSTEMS PLANNING AND DEVELOPMENT ACT OF 2005

* * * * * * *

TITLE XII—TRAUMA CARE

PART A—GENERAL AUTHORITY AND DUTIES OF SECRETARY

SEC. 1201. ESTABLISHMENT.

(a) IN GENERAL.—The Secretary*, acting through the Administrator of the Health Resources and Services Administration,* shall, with respect to trauma care—

(1) * * *

(2) * * *

(3) collect, compile, and disseminate information on the achievements of, and problems experienced by, State and local agencies and private entities in providing trauma care and emergency medical services and, in so doing, give special consideration to the unique needs of rural areas;

[(3)**]** *(4)* provide to State and local agencies technical assistance *to enhance each State's capability to develop, implement, and sustain the trauma care component of each State's plan for the provision of emergency medical services*;

[(4)**]** *(5)* sponsor workshops and conferences**[**.**]***; and*

(6) promote the collection and categorization of trauma data in a consistent and standardized manner.

(b) GRANTS, COOPERATIVE AGREEMENTS, AND CONTRACTS.—The Secretary*, acting through the Administrator of the Health Resources and Services Administration,* may make grants, and enter into cooperative agreements and contracts, for the purpose of carrying out subsection (a).

[(c) ADMINISTRATION.—The Administrator of the Health Resources and Services Administration shall ensure that this title is administered by the Division of Trauma and Emergency Medical Systems within such Administration. Such division shall be headed by a director appointed by the Secretary from among individuals who are knowledgeable by training or experience in the development and operation of trauma and emergency medical systems.**]**

* * * * * * *

[SEC. 1202. CLEARINGHOUSE ON TRAUMA CARE AND EMERGENCY MEDICAL SERVICES.

[(a) ESTABLISHMENT.—The Secretary shall be contract provide for the establishment and operation of a National Clearinghouse on Trauma Care and Emergency Medical Services (hereafter in this section referred to as the "Clearinghouse").

[(b) DUTIES.—The Clearinghouse shall—

[(1) foster the development of appropriate, modern trauma care and emergency medical services (including the development of policies for the notification of family members of individuals involved in medical emergencies) through the sharing of information among agencies and individuals involved in planning, furnishing, and studying such services and care;

[(2) collect, compile, and disseminate information on the achievements of, and problems experienced by, State and local agencies and private entities in providing trauma care and emergency medical services and, in so doing, give special consideration of the unique needs of rural areas;

[(3) provide technical assistance relating to trauma care and emergency medical services to State and local agencies; and

[(4) sponsor workshops and conferences on trauma care and emergency medical services.

[(c) FEES AND ASSESSMENTS.—A contract entered into by the Secretary under this section may provide that the Clearinghouse charge fees or assessments in order to defray, and beginning with fiscal year 1992, to cover, the costs of operating the Clearinghouse.**]**

SEC. [1203]. *1202* ESTABLISHMENT OF PROGRAMS FOR IMPROVING TRAUMA CARE IN RURAL AREAS.

(a) IN GENERAL.—* * *

(1) * * *

(2) by developing model curricula*, such as advanced trauma life support,* for training emergency medical services personnel, including first responders, emergency medical technicians, emergency nurses and physicians, and paramedics—* * *

* * * * * * *

(4) by developing innovative protocols and agreements to increase access to prehospital care and equipment necessary for the transportation of seriously injured patients to the appropriate facilities; **[**and**]**

(5) by evaluating the effectiveness of protocols with respect to emergency medical services and systems**[**.**]***; and*

(6) by increasing communication and coordination with State trauma systems.

* * * * * * *

SEC. 1212. REQUIREMENT OF MATCHING FUNDS FOR FISCAL YEARS SUBSEQUENT TO FIRST FISCAL YEAR OF PAYMENTS.

(a) NON-FEDERAL CONTRIBUTIONS.—

(1) IN GENERAL.—* * *

(A) for the second fiscal year of such payments to the State, not less than $1 for each $1 of Federal funds provided in such payments for such fiscal year; **[**and**]**

[(B) for any subsequent fiscal year of such payments to the State, not less than $3 for each $1 of Federal funds provided in such payments for such fiscal year.**]**

(B) for the third fiscal year of such payments to the State, not less than $1 for each $1 of Federal funds provided in such payments for such fiscal year;

(C) for the fourth fiscal year of such payments to the State, not less than $2 for each $1 of Federal funds provided in such payments for such fiscal year; and

(D) for the fifth fiscal year of such payments to the State, not less than $2 for each $1 of Federal funds provided in such payments for such fiscal year.

* * * * * * *

(b) * * *

(1) a State may make the non-Federal contributions required in such subsection in cash or in kind, fairly evaluated, including plant, equipment, or services; *and*

(2) the Secretary may not, in making a determination of the amount of non-Federal contributions, include amounts provided by the Federal Government or services assisted or subsidized to any significant extent by the Federal Government**[**; and**]**.

[(3) the Secretary shall, in making such a determination, include only non-Federal contributions in excess of the amount of non-Federal contributions made by the State during fiscal year 1990 toward—

[(A) the costs of providing trauma care in the State; and

[(B) the costs of improving the quality and availability of emergency medical services in rural areas of the State.]

* * * * * * *

SEC. 1213. REQUIREMENTS WITH RESPECT TO CARRYING OUT PURPOSE OF ALLOTMENTS.

(a) TRAUMA CARE MODIFICATIONS TO STATE PLAN FOR EMERGENCY MEDICAL SERVICES.—* * *

(1) * * *

(2) * * *

(3) subject to subsection (b), contains *nationally recognized* standards and requirements for the designation of level I and level II trauma centers, and in the case of rural areas level III trauma centers (including trauma centers with specified capabilities and expertise in the care of the pediatric trauma patient), by such entity, including standards or requirements for—

* * * * * * *

(5) subject to subsection (b), contains *nationally recognized* standards and requirements for medically directed triage and transport of severely injured children to designated trauma centers with specified capabilities and expertise in the care of the pediatric trauma patient;

(6) [specifies procedures for the evaluation of designated] *utilizes a program with procedures for the evaluation of* trauma centers (including centers described in paragraph (5)) and trauma care systems;

(7) provides for the establishment and collection of data *in accordance with data collection requirements developed in consultation with surgical, medical, and nursing specialty groups, State and local emergency medical services directors, and other trained professionals in trauma care* from each designated trauma center in the State of a central data reporting and analysis system—

(A) to identify the number of severely injured trauma patients *and the number of deaths from trauma* within regional trauma care systems in the State;

* * * * * * *

(F) to identify patients transferred within a regional trauma system, including reasons for such transfer *and the outcomes of such patients*;

* * * * * * *

(9) * * *

(10) coordinates planning for trauma systems with State disaster emergency planning and bioterrorism hospital pregardeness planniong;

[10] *(11)* * * *

[11] *(12)* * * *

(b) CERTAIN STANDARDS WITH RESPECT TO TRAUMA CARE CENTERS AND SYSTEMS.—

(1) IN GENERAL.—* * *

(A) take into account national standards [concerning such] *that outline resources for optimal care of the injured patient*;

* * * * * * *

(D) beginning in fiscal year [1992] *2005*, take into account the model plan described in subsection (c).

* * * * * * *

(3) APPROVAL BY SECRETARY.—* * *

(A) in the case of payments for fiscal year [1991] *2005* and subsequent fiscal years, the State has not taken into account national standards, including those of the American College of Surgeons, the American College of Emergency Physicians and the American Academy of Pediatrics, in adopting standards under this subsection; or

(B) in the case of payments for fiscal year [1992] *2005* and subsequent fiscal years, the State has not, in adopting such standards, taken into account the model plan developed under subsection (c).

(c) MODEL TRAUMA CARE PLAN.—Not later than 1 year after the date of the enactment of the Trauma Care Systems Planning and Development Act of [1990, the Secretary shall develop a model plan] *2005, the Secretary shall update the model plan* for the designation of trauma centers and for triage, transfer and transportation policies that may be adopted for guidance by the State. Such plan shall—

* * * * * * *

SEC. 1214. REQUIREMENT OF SUBMISSION TO SECRETARY OF TRAUMA PLAN AND CERTAIN INFORMATION.

(a) TRAUMA PLAN.—

(1) IN GENERAL.—For fiscal year [1991] *2005* and subsequent fiscal years, the Secretary may not make payments under section 1211(a) unless, subject to paragraph (2), the State involved submits to the Secretary the trauma care component of the State plan for the provision of emergency medical services *that includes changes and improvements made and plans to address deficiencies identified*.

(2) INTERIM PLAN OR DESCRIPTION OF EFFORTS.—For fiscal year [1991] *2005*, if a State has not completed the trauma care component of the State plan described in paragraph (1), the State may provide, in lieu of a completed such component, an interim component or a description of efforts made toward the completion of the component.

* * * * * * *

SEC. 1215. RESTRICTIONS ON USE OF PAYMENTS.

(a) IN GENERAL.—* * *

(1) subject to section 1233, for any purpose other than developing, implementing, and monitoring the modifications required by section 1211(b) to be made to the State plan for the provision of emergency medical services[.]*;*

* * * * * * *

SEC. 1216. REQUIREMENT OF REPORTS BY STATES.

[(a) IN GENERAL.—The Secretary may not make payments under section 1211(a) for a fiscal year unless the State involved agrees to prepare and submit to the Secretary an annual report in such form and containing such information as the Secretary determines (after consultation with the States) to be necessary for—

[(1) securing a record and a description of the purposes for which payments received by the State pursuant to such section were expended and of the recipients of such payments; and

[(2) determining whether the payments were expended in accordance with the purpose of the program involved.

[(b) AVAILABILITY TO PUBLIC OF REPORTS.—The Secretary may not make payments under section 1211(a) unless the State involved agrees that the State will make copies of the report described in subsection (a) available for public inspection.

[(c) EVALUATIONS BY COMPTROLLER GENERAL.—The Comptroller General of the United States shall evaluate the expenditures by States of payments under section 1211(a) in order to assure that expenditures are consistent with the provisions of this part, and not later than December 1, 1994, prepare and submit to the Committee on Energy and Commerce of the House of Representatives and the Committee on Labor and Human Resources of the Senate a report concerning such evaluation.]

SEC. 1216. [RESERVED].

* * * * * * *

SEC. 1222. REPORT BY SECRETARY.

Not later than October 1, [1995] *2007*, the Secretary shall report to the appropriate committees of Congress on the activities of the States carried out pursuant to section 1211. Such report shall include an assessment of the extent to which Federal and State efforts to develop systems of trauma care and to designate trauma centers have reduced the incidence of mortality, and the incidence of permanent disability, resulting from trauma. Such report may include any recommendations of the Secretary for appropriate administrative and legislative initiatives with respect to trauma care.

* * * * * * *

SEC. 1232. FUNDING.

[(a) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out parts A and B, there are authorized to be appropriated $6,000,000 for fiscal year 1994, and such sums as may be necessary for each of the fiscal years 1995 through 2002.]

(a) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out parts A and B, there are authorized to be appropriated $12,000,000 for fiscal year 2005, and such sums as may be necessary for each of the fiscal years 2006 through 2009.

(b) ALLOCATION OF FUNDS BY SECRETARY.—

(1) * * *

(2) RURAL GRANTS.—For the purpose of carrying out section [1204] *1202*, the Secretary shall make available 10 percent of the amounts appropriated for a fiscal year under subsection (a).

* * * * * * *

[Part E—Miscellaneous Programs]

PART E—MISCELLANEOUS PROGRAMS

SEC. 1251. RESIDENCY TRAINING PROGRAMS IN EMERGENCY MEDICINE.

(a) IN GENERAL.—* * *

* * * * * * *

(c) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there is authorized to be appropriated $400,000 for each of the fiscal years **[**1993 through 1995**]** *2005 through 2009*.

* * * * * * *

SEC. 1252. STATE GRANTS FOR [DEMONSTRATION] PROJECTS REGARDING TRAUMATIC BRAIN INJURY.

* * * * * * *

SEC. 1254. INSTITUTE OF MEDICINE STUDY.

(a) IN GENERAL.—The Secretary shall enter into a contract with the Institute of Medicine of the National Academy of Sciences, or another appropriate entity, to conduct a study on the state of trauma care and trauma research.

(b) CONTENT.—The study conducted under subsection (a) shall—

(1) examine and evaluate the state of trauma care and trauma systems research (including the role of Federal entities in trauma research) on the date of enactment of this section, and identify trauma research priorities;

(2) examine and evaluate the clinical effectiveness of trauma care and the impact of trauma care on patient outcomes, with special attention to high-risk groups, such as children, the elderly, and individuals in rural areas;

(3) examine and evaluate trauma systems development and identify obstacles that prevent or hinder the effectiveness of trauma systems and trauma systems development;

(4) examine and evaluate alternative strategies for the organization, financing, and delivery of trauma care within an overall systems approach; and

(5) examine and evaluate the role of trauma systems and trauma centers in preparedness for mass casualties.

(c) REPORT.—Not later than 2 years after the date of enactment of this section, the Secretary shall submit to the appropriate committees of Congress a report containing the results of the study conducted under this section.

(d) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $750,000 for each of fiscal years 2005 and 2006.

* * * * * * *

PART F—INTERAGENCY PROGRAM FOR TRAUMA RESEARCH

SEC. 1261. ESTABLISHMENT OF PROGRAM.

(a) IN GENERAL.—The Secretary, acting through the Director of the National Institutes of Health (in this section referred to as the "Director"), shall establish a comprehensive program of **[**conducting basic and clinical research on trauma (in this section referred to as

the "Program"). The Program shall include research regarding the diagnosis, treatment, rehabilitation, and general management of trauma.] *basic and clinical research on trauma (in this section referred to as the "Program"), including the prevention, diagnosis, treatment, and rehabilitation of trauma-related injuries.*

[(b) PLAN FOR PROGRAM.—

[(1) IN GENERAL.—The Director, in consultation with the Trauma Research Interagency Coordinating Committee established under subsection (g), shall establish and implement a plan for carrying out the activities of the Program, including the activities described in subsection (d). All such activities shall be carried out in accordance with the plan. The plan shall be periodically reviewed, and revised as appropriate.

[(2) SUBMISSION TO CONGRESS.—Not later than December 1, 1993, the Director shall submit the plan required in paragraph (1) to the Committee on Energy and Commerce of the House of Representatives, and to the Committee on Labor and Human Resources of the Senate, together with an estimate of the funds needed for each of the fiscal years 1994 through 1996 to implement the plan.]

(b) PLAN FOR PROGRAM.—The Director shall establish and implement a plan for carrying out the activities of the Program, taking into consideration the recommendations contained within the report of the NIH Trauma Research Task Force. The plan shall be periodically reviewed, and revised as appropriate.

* * * * * * *

(d) CERTAIN ACTIVITIES OF PROGRAM.—The Program shall include—

(1) * * *

* * * * * * *

(4) the authority to make awards of grants or contracts to public or nonprofit private entities for the conduct of basic and applied research regarding traumatic brain injury, which research may include—

(A) * * *

(B) the development, modification and evaluation of therapies that retard, prevent or reverse brain damage after [acute head injury] *traumatic brain injury*, that arrest further deterioration following injury and that provide the restitution of function for individuals with long-term injuries;

* * * * * * *

(D) the development of programs that increase the participation of academic centers of excellence in [head] *traumatic* brain injury treatment and rehabilitation research and training; and

* * * * * * *

[(g) COORDINATING COMMITTEE.—

[(1) IN GENERAL.—There shall be established a Trauma Research Interagency Coordinating Committee (in this section referred to as the "Coordinating Committee").

[(2) DUTIES.—The Coordinating Committee shall make recommendations regarding—

[(A) the activities of the Program to be carried out by each of the agencies represented on the Committee and the amount of funds needed by each of the agencies for such activities; and

[(B) effective collaboration among the agencies in carrying out the activities.

[(3) COMPOSITION.—The Coordinating Committee shall be composed of the Directors of each of the agencies that, under subsection (c), have responsibilities under the Program, and any other individuals who are practitioners in the trauma field as designated by the Director of the National Institutes of Health.]

[(h)] *(g)* DEFINITIONS.—For purposes of this section:

(1) * * *

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[(i)] *(h)* AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years [2001 through 2005] *2005 through 2009*.

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